STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155824	A. BUILDING _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBROOKE OF SOUTH BEND	**52565 STATE ROAD 933 SOUTH BEND, IN 46637**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This survey was for the Investigation of Complaint IN00168654 and Complaint IN00169644. This visit was in conjunction with Post Survey Revisit (PSR) to the Investigation of Complaint IN00164273 completed on February 11, 2015. Complaint IN00168654 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00169644 - Substantiated. No deficiencies related to the allegations are cited. Survey date: March 25, 2015 Facility number: 013302 Provider number: 155824 AIM number: N/A Survey team: Honey Kuhn, RN Census bed type: SNF: 33 Residential: 20 Total: 53 Census payor type: Medicare: 24 Other: 9 Total: 33 Sample: 5 Wellbrooke of South Bend was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00168654 and Complaint	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155824	A. BUILDING _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBROOKE OF SOUTH BEND	**52565 STATE ROAD 933 SOUTH BEND, IN 46637**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 IN00169644. Quality Review completed on March 30, 2015, by Brenda Meredith, R.N.	F 000		